AmeriHealth Inc./AmeriHealth HMO and United Food and Commercial Workers Union, Local 56, AFL–CIO, Petitioner. Case 4–RC–19260

October 18, 1999

ORDER DENYING REVIEW

BY CHAIRMAN TRUESDALE AND MEMBERS FOX AND BRAME

The National Labor Relations Board has delegated its authority in this proceeding to a three-member panel, which has considered the Petitioner's request for review of the Regional Director's Decision and Order (pertinent portions of which are attached). The request for review is denied as it raises no substantial issues warranting review.[1]

APPENDIX

DECISION AND ORDER

On January 8, 1998, the undersigned Regional Director administratively dismissed the subject petition on the ground that the petitioned-for physicians are independent contractors. On August 27, 1998, the National Labor Relations Board issued a Decision on Review, Direction, and Order Remanding for a Hearing which, inter alia, reinstated the petition and remanded the case to the undersigned for a hearing "for the purpose of receiving evidence to resolve the question of whether the petitioned-for physicians are or are not employees within the meaning of the Act and the issuance of a decision." Because the case "involves an important issue of first impression," the Board decided that "the best way . . . to assess the total factual context here is to provide for the full development of the record through a hearing." In particular, the Board stated:

> Such evidence will provide a more complete picture of the day-to-day interaction between the physicians and the HMOs [health maintenance organizations] and the impact of the HMOs on the physicians' access to and care of patients. It will also provide a more complete picture of the nature of the overall practices of the physicians who contract with the HMOs and the impact of managed health care in Atlantic and Cape May Counties, New Jersey, on such practices.

Following the Board's Decision on Review, the Region conducted 14 days of hearing between November 4 and December 16, 1998, compiling a record of approximately 2300 transcript pages and 4500 pages of exhibits. The parties filed briefs on January 16, 1999. Upon the entire record in this proceeding, the undersigned finds:

1. The hearing officers' rulings made at the hearing are free from prejudicial error and are hereby affirmed.

2. The Employer is engaged in commerce within the meaning of the National Labor Relations Act and it will effectuate the purposes of the Act to assert jurisdiction herein.

3. The labor organization involved claims to represent certain individuals which it contends are employees of the Employer.

4. On October 27, 1997, the Petitioner filed a petition seeking to represent "all primary care and specialty physicians employed by AmeriHealth Corporation in Atlantic and Cape May Counties, New Jersey." The parties stipulated that, as of the time of the hearing in November 1998, there were 652 physicians in the proposed bargaining unit, including 172 primary care physicians (PCPs) and 480 specialty physicians.

The Identity of the Employer

The parties disagree about the correct name of the asserted Employer. AmeriHealth HMO, Inc. is a wholly-owned subsidiary of AmeriHealth, Inc., a holding company that conducts no operations and is wholly owned by Independence Blue Cross, a large health care insurance company based in Philadelphia, Pennsylvania. AmeriHealth HMO, Inc. operates an HMO in New Jersey. AmeriHealth Insurance Company of New Jersey is another wholly owned subsidiary of Independence Blue Cross, and holds a license for preferred provider (PPO) insurance plans and traditional indemnity insurance plans in New Jersey. AmeriHealth HMO, Inc. markets a variety of HMO plans and, through an arrangement with AmeriHealth Insurance Company of New Jersey, also markets PPO and indemnity plans. AmeriHealth HMO, Inc. has operated in New Jersey since the late 1980's or early 1990's, though before 1995 the entity operated under different names, such as Delaware Valley HMO, Inc. d/b/a Keystone Health Plan New Jersey.

"AmeriHealth HMO, Inc." is the name which appears on the standard contract governing the physicians' provision of medi-

[1] The sole issue presented for review is whether the Regional Director erred in finding that the petitioned-for primary care and specialty physicians are independent contractors and not employees within the meaning of Sec. 2(3) of the Act. We agree with the Regional Director that the consideration of all factors of the common law agency test as expressed in the Board's decision in *Roadway Package System*, 326 NLRB 842 (1998), favor a finding of independent contractor status for the petitioned-for physicians. We particularly agree with the Regional Director's finding that the relationship between the petitioned-for physicians and AmeriHealth is similar to the relationship between the advertising agency and the freelance advertisement photographers who were found to be independent contractors in *Young & Rubicam International*, 226 NLRB 1271 (1976).

Contrary to the Regional Director, however, we accord little weight to the fact that AmeriHealth does not exercise substantial control with respect to the physicians' physical conduct in the performance of services such as examining patients, diagnosing illnesses, and performing specific procedures, since it is not customary in the medical profession for fully trained physicians, including traditional staff physicians employed by hospitals or clinics, to be subject to substantial controls over the manner in which they perform their professional duties. See Restatement (Second) of Agency, Sec. 220, Comment on Subsection (2)(i) (emphasizing importance of the "custom of the community as to the control ordinarily exercised in a particular occupation"). Similarly, we accord less weight than the Regional Director to the absence of on-site supervision in light of AmeriHealth's other means of monitoring the physicians' performance by paperwork, telephone, and computer. See e.g., *Michigan Eye Bank*, 265 NLRB 1377, 1379 (1982), and *Mission Foods Corp.*, 280 NLRB 251, 251 (1986) (finding meaningful oversight by employer despite absence of daily supervision).

In denying review, we are not necessarily precluding a finding that physicians under contract to health maintenance organizations may, in other circumstances, be found to be statutory employees.

Contrary to his colleagues, Member Brame does not find that the Regional Director accorded undue weight to the degree of control which AmeriHealth exercises over the physicians' performance of medical services or to the absence of the on-site supervision.

Member Brame additionally notes that he dissented from the Board's order remanding this case to the Regional Director to hold a hearing and would have affirmed the Regional Director's initial administrative dismissal of the petition. See *AmeriHealth Inc./AmeriHealth HMO*, 326 NLRB 509, 510 (1998).

cal services to AmeriHealth HMO members, which is entitled "Physician Managed Care Agreement." According to a standard "AmeriHealth HMO, Inc. Affiliate Program Attachment" to the Agreement, physicians who contract with AmeriHealth HMO, Inc. "shall provide Covered Services within the scope of Physician's practice to Participants in Programs of AmeriHealth Affiliates in accordance with the terms of the Agreement and applicable Program Attachments." The Affiliate Program Attachment lists six HMOs, eight PPOs and seven indemnity plans that are current "AmeriHealth Affiliates." The listed HMOs include Keystone Health Plan East, Inc.; AmeriHealth HMO, Inc. (Delaware Division); AmeriHealth Integrated Benefits, Inc. d/b/a AmeriHealth Administrators; Healthcare Delaware, Inc.; Blair Mill Administrators, Inc.; and Keystone Health Systems, Inc. The Agreement also states that the physician's provision of services to participants in such Affiliates' programs is "subject to the applicable utilization management, quality management and Participant grievance procedures and requirements established by the AmeriHealth Affiliate." In its correspondence with the petitioned-for physicians about their performance of services under the Agreements, AmeriHealth HMO, Inc. uses a letterhead that also carries the name of AmeriHealth Insurance Company of New Jersey.

The petition names "AmeriHealth Inc./AmeriHealth HMO" as the Employer. At the opening of the hearing, the parties stipulated that the "correct name of the employer" is "AmeriHealth HMO, Inc." During the hearing, the Petitioner first withdrew from the stipulation on the Employer's name, then reentered the stipulation, and still later asserted that it agreed to the stipulated name "with the view that it would encompass the entities that are described in the [Physician Managed Care Agreements]." In its post-hearing brief, the Petitioner contends that the Employer "includes AmeriHealth HMO and its affiliates, as defined in" the Agreements. As the parties stipulated that "AmeriHealth HMO, Inc." is the Employer's correct name, and all petitioned-for physicians have contracted with AmeriHealth HMO, Inc. (or with the corporate entity that is now so named), this Decision will focus on the relationship between AmeriHealth HMO, Inc. (AmeriHealth), and the physicians. Nonetheless, the physicians' involvement with the affiliates pursuant to their contracts with AmeriHealth may be relevant to the issue in the instant proceeding.

Recent Changes in the Health Care Industry

At the hearing, the Petitioner adduced testimony from Dr. Alan Hillman of the University of Pennsylvania, an expert in health care economics and managed care and the use of financial incentives and nonfinancial rules and regulations by managed care organizations (MCOs) to influence physicians' behavior. Dr. Hillman provided a general overview of conditions in the health care economy as they exist now and how they have developed in recent years.

Before the recent growth of managed care, physicians in private practice normally had complete authority over the provision of care to their patients, and insurance was, for the most part, indemnity-oriented. The insurance company paid for whatever services the physician thought were necessary on a fee for service basis. The physicians and insurance companies each had separate relationships with the patient, and for the most part, dealt with each other only to exchange information for payment purposes. Many believe that this essentially unfettered provision of fee for service care was a primary cause of the dramatic increase in health care costs and health insurance premiums in the 1970's and 1980's. As premiums increased each year, employers and health care consumers sought constraints on these costs, and managed care provided an alternative. Previously, physicians in private practice did not have contracts with insurance carriers that controlled or influenced the physicians' practice of medicine. Such contracts, however, are now a central element of the managed care system. In managed care, the doctor-patient relationship is influenced and constrained by a manager who, to varying extents, influences or determines what procedures the doctor performs, and how and where they are performed, all with a goal of providing good medical care as efficiently as possible.

Health maintenance organizations (HMOs) are a form of managed care that deliver a comprehensive set of health care services, including preventive care and primary care, that traditional indemnity-based care either did not promote or did not even cover. Nationwide, HMOs have enrolled approximately 35 percent of American insured patients. There are several kinds of HMOs: "Staff model" HMOs operate medical care facilities, provide the medical equipment, and directly employ the physicians, nurses and other health care providers who staff the facility. "Group model" HMOs contract with a separate group medical practice to provide all medical services for the HMO, and the group practice provides the facilities and equipment and employs physicians and other health care staff. "Direct contracting" or "independent practice association" (IPA) HMOs contract with an array of existing individual practitioners and group medical practices throughout a community, who in turn provide the facilities and equipment.

Preferred provider organization (PPOs) are something of a hybrid. Like HMOs, PPOs have a closed panel or network of providers. PPO members may choose a provider outside the panel and still have the services covered, only the level of coverage (e.g., the percentage of costs reimbursed) is lower than if the member uses a panel provider. AmeriHealth Insurance Company of New Jersey offers a PPO called AmeriHealth Personal Choice.

The goal of MCOs is to provide the appropriate amount of care, neither too much nor too little, in the most efficient way possible. Where they do not provide the care themselves, but contract with providers to do so, they use a variety of techniques to structure the relationship to meet these efficiency goals. According to Dr. Hillman, physicians' pay constitutes about 22 percent of health care expenses generally, and physicians control another 62 percent by what they order through test procedures, referrals, surgeries, hospitalizations, and other care. MCOs therefore attempt to control health care costs by influencing physician behavior. MCOs apply rules and regulations, such as prior approval for procedures, mandatory second opinions, utilization reviews before and after treatment, protocols and guidelines for particular medical problems or preventive treatment, and quality assurance mechanisms. MCOs also use financial incentives to control costs or reward the efficient provision of care, through bonuses or penalties based on productivity, quality of care, or meeting a budget. MCOs' two basic methods of payment to providers (in addition to salaries in "staff model" HMOs) are fee for service, which is the payment of a fixed amount per service or procedure, and "capitation," which is the payment of a fixed amount per patient per month regardless of the number of services or procedures provided to the patient. MCOs, and HMOs in particular, vary widely in the

extent of control they exercise, or attempt to exercise, over the physicians who provide care to their members.

Dr. Hillman testified that under traditional indemnity-based fee for service arrangements, the physician had an economic incentive to provide as many services as possible, whether truly needed or not, and there were few if any incentives to be cost conscious. The more services the physician provided, the more he/she was paid. MCOs, however, have placed substantial limits on fee for service-based care through the use of rules and incentives. Under managed care capitation arrangements, the physician has an incentive to acquire as many healthy patients as possible and see them as infrequently as possible, because the physician is paid the same regardless of how often he/she sees the patients. Thus, under capitation there is an incentive to provide less care, rather than more. Here too, MCOs use rules and incentives to counterbalance the economic incentive.

According to Dr. Hillman, managed care in general, and HMOs in particular, have altered not only the relationship between physicians and patients, but also the means by which physicians acquire patients. Before the advent of managed care, physicians obtained patients primarily by word-of-mouth referrals, and traditional indemnity-based insurance covered needed services regardless of which physician the patient selected to provide the services. An HMO, on the other hand, generally covers nonemergency services only if provided by physicians who are part of the HMO's network or panel of health care providers. Patients are often restricted in their choice of physicians by the panels of providers in the MCOs offered by their employer. Fewer patients are now referred by word-of-mouth, and physicians must rely in part on the marketing ability of the MCOs with whom they have contracted to attract new members and sign up new employers.

The Physicians' Contracts with AmeriHealth

AmeriHealth General Manager Dr. Richard Gilfillan described AmeriHealth's business as providing "access to and coverage for a defined set of covered services within the confines or context of an overall benefit plan." According to AmeriHealth's "Member Handbook," AmeriHealth provides "access to quality health care coverage." The Member Handbook's "Summary of Benefits" describes the covered benefits to which members are entitled. Once members have selected a primary care provider (PCP), they may obtain, through their PCP (and, for female members, through their obstetrician or gynecologist), an array of routine and preventive care. Members are also entitled to a broad range of other inpatient and outpatient medical services from PCPs and specialty physicians provided that (1) the services are "medically necessary," and (2) the services are provided or referred by the member's PCP, and "preapproved" by AmeriHealth where such pre-approval is required. The Member Handbook also lists number of particular medical services that are specifically excluded from coverage.

AmeriHealth does not own or directly operate any health care facilities for its members. Rather, AmeriHealth is a "direct contracting" model HMO which has recruited a network of participating providers throughout New Jersey to provide services to its members. These providers include physicians, acute care hospitals, nursing homes, home health agencies, durable medical equipment companies, IV therapy companies, and include the petitioned-for physicians in Cape May and Atlantic Counties. AmeriHealth's network of PCPs includes family practitioners, general internists, pediatricians and general practitioners, and its network of specialty physicians includes all other medical specialties.

In order to become part of AmeriHealth's network, physicians must enter into Physician Managed Care Agreements with AmeriHealth. These standard form Agreements include the "AmeriHealth HMO, Inc. Affiliate Program Attachment," discussed above, and a 1998 "Addendum" that amends the Agreement to comply with recent State and Federal regulation. PCPs' Agreements also include a standard "HMO Primary Care Physician Program Attachment" to the Agreement, and specialty physicians' Agreements include a standard "HMO Specialty Care Physician Program Attachment."

According to the Agreement's "Purpose" section, AmeriHealth contracts with employers and individuals, among others, "to provide, insure, arrange for or administer the provision of health care services," and "contracts with physicians, hospitals and other health care practitioners and entities, to provide, arrange for or administer, at predetermined rates, the delivery of such health care services." The Agreement provides that the physician "will render Covered Services to Participants" and do so "with the same standard of care, skill and diligence customarily used by similar physicians in the community in which such services are rendered," and "in the same manner, in accordance with the same standards, and with the same availability, as offered to other patients."

While AmeriHealth "makes no representations or guarantees concerning the number of Participants it can or will refer to Physician," PCPs are required to accept "all Members who select Physician for Primary Care Services" up to at least 150 members, and specialty physicians are required to "provide all specialty care Covered Services within the scope of Physician's practice that are required by Participants." PCPs have the option "closing their panel" after they have reached 150 members by giving 90-day notice to AmeriHealth, though they must continue "to accept for diagnosis and treatment all Members who select" the PCP for primary care services during the 90-day period. There is no similar "panel closing" option for specialty physicians. Where a member has selected a PCP, but the PCP does not wish to have that member as a patient, the PCP cannot unilaterally remove the patient from the PCP's panel but must instead make a request to AmeriHealth or the patient that the patient transfer to another PCP.

The Agreement requires that the physician "act in accordance with . . . Program Requirements," which are defined as "the rules and procedures, including Utilization Management and Quality Management procedures, that establish conditions to be followed by participating Providers," and includes "the requirements set forth in the applicable Provider Manual." "Quality Management" is defined as "the processes established and operated by AmeriHealth HMO or its designee relating to the quality of Covered Services." "Utilization Management" is defined as "the process to review and determine whether certain health care services provided or to be provided to Participants are in accordance with Program Requirements." AmeriHealth's current "Provider Manual" is entitled the "Physician's Office Manual for New Jersey." The Office Manual's approximately 275 pages describe AmeriHealth's various plans, and set forth policies and procedures on referrals, record keeping, reimbursement, quality management, credentialing and recredentialing, site standards, preventive care guidelines, and precertification, and describe AmeriHealth's protocols and guidelines for particular medical conditions.

In return for the physician's services under the Agreement, AmeriHealth agrees to reimburse the physician on either a fee for service basis or capitation basis. Except for certain radiologists who are paid by capitation, specialty physicians are paid only on a fee for service basis according to AmeriHealth's "maximum fee schedule in effect at the time of service." Payment to PCPs for "primary care covered services," which include most routine, urgent and emergency care that PCPs provide, is based either on capitation or fee for service. PCPs who have 100 or fewer AmeriHealth members in their member panel can elect to receive payment on either basis. Once the PCP's member panel exceeds 100 (or 100 times the number of PCPs in a group practice), the Agreement requires payment by capitation. AmeriHealth's capitation schedule involves payment of a fixed amount per member per month, based on the member's age. Capitation rates for different plans vary depending on the plans' copay amounts. Payment to PCPs for care other than "primary care covered services" is by fee for service. Of the 172 PCPs in the petitioned-for unit, only 69 are paid on a capitation basis, and nearly all of those have more than 100 AmeriHealth patients.

In addition to fee for service or capitation payments from AmeriHealth, physicians also collect copayments directly from members. Copayments vary depending on the member's particular plan. AmeriHealth does not pay any of the physicians on either an hourly or a salaried basis, and provides no benefits to the physicians. Unlike some other MCOs described by Dr. Hillman, AmeriHealth does not impose penalties or provide bonuses or other financial incentives to physicians based on productivity or quality. The Agreements state that physicians "shall accept the rates set forth in this Agreement as payment in full for all services provided to Participants pursuant to this Agreement." Pursuant to New Jersey law, physicians are prohibited, even in the event AmeriHealth fails to pay the physicians, or breaches the Agreement, or becomes insolvent, from billing members for "covered services."

The Agreement includes the following language in a subsection entitled "Independent Contractor Relationship":

> This Agreement is not intended to create nor shall be construed to create any relationship between AmeriHealth HMO and Physician other than that of independent persons or entities contracting for the purpose of effecting provisions of this Agreement. Neither party nor any of their representatives shall be construed to be the agent, employer, employee or representative of the other.

In practice, AmeriHealth does not withhold taxes from payments to a physician or the physician's practice, and reports those payments on an IRS Form 1099 rather than a W-2.

The standard Agreement is for a 1-year term, but after the initial year the Agreement automatically renews each year for another 1-year term. Most physicians continue their contractual relationship with AmeriHealth from year to year. After the first 1-year term, the Agreement "may be terminated by either party at any time" with 60 days' notice. The Agreement gives AmeriHealth the right to terminate "immediately upon written notice" if the physician's license is restricted, or if the physician fails to "provide Covered services with the same standard of care, skill and diligence customarily used by similar physicians in the community in which such services are rendered," or if the physician breaches any term of the Agreement, or any "Program Requirement," which, as noted above, includes every rule and policy in AmeriHealth's Physician's Office Manual. Physicians have no similar right of immediate termination. Even AmeriHealth's mid-1998 unilateral implementation of a new fee schedule, which included some significant reductions in fees, apparently did not give physicians the right to terminate immediately, as AmeriHealth reminded physicians when they sought to do so.

The 1998 Addendum to the Physician Managed Care Agreement includes new notice and hearing requirements in the event that AmeriHealth wishes to terminate the Agreement, all of which terms are dictated by New Jersey law. AmeriHealth must give 90 days written notice of termination and provide a hearing, if requested. The required notice and opportunity for a hearing do not apply where, among things, there has been "a breach of the Agreement by the physician." Pursuant to New Jersey law, physicians are protected from termination and penalty "solely because of filing a complaint or appeal regarding a utilization management determination made by AmeriHealth or because [the physician] acts as an advocate for the patient in seeking appropriate, medically necessary services."

The Physicians' Practices

In 1996, AmeriHealth paid $1.1 million in fees to its provider physicians in Atlantic and Cape May Counties, a figure that grew to $6.8 million in 1997. However, AmeriHealth's membership constitutes only a small portion of the insured population in southern New Jersey: approximately 4 percent in Atlantic County and 7 percent in Cape May County. There are a number of competing HMOs, PPOs and indemnity plans. The record does not indicate what portion of the insured population of those counties is enrolled in HMOs or other forms of MCOs.

AmeriHealth's Agreements with physicians do not contain noncompetition clauses, and the physicians are free to contract with, or even serve as advisors to, competing insurance companies. Information reported to AmeriHealth by the physicians in the unit sought by the Petitioner suggests that the physicians contract with, on average, five or six other MCOs or indemnity insurance companies. The physicians also treat patients who are covered by Medicare, as well as patients who self-pay. For the six PCPs and specialty physicians who testified at the hearing, AmeriHealth revenues constituted from 1 to 12 percent of their practices' total income in 1997, and on average about 4 percent of total practice income. It appears, though, that the number of AmeriHealth members in the physicians' practices has grown significantly, as reflected by the increase in AmeriHealth's payouts to physicians from 1996 to 1997.

AmeriHealth also imposes no restrictions on competition between AmeriHealth's network physicians, and, in fact, the evidence suggests that a number of the network physicians provide similar services to patients in the same geographic area as other network physicians. Most or all of the physicians have listings or advertisements in local "Yellow Pages," and some have advertisements elsewhere, and even websites. Two physicians who testified have a weekly television show, and one has a radio show.

As noted, Dr. Hillman testified that physicians have become dependent to some degree on MCOs for access to patients. Contrary to the Petitioner (P. br. 6, 13, 93), however, the record does not establish that AmeriHealth controls the physicians' access to patients, or that the physicians' own marketing efforts are less important than AmeriHealth's marketing efforts or the marketing efforts of MCOs generally. The physicians continue

to advertise their practices, and there is evidence that patients or employers may select an HMO based on which physicians are in the HMO's network. Indeed, one physician testified that his patients rely on him to direct them to insurance companies with whom the physician's practice contracts as a provider, and many of the physician's senior citizen patients switched to AmeriHealth on the physician's recommendation. AmeriHealth clearly has no control over the physicians' access to patients who are not AmeriHealth members. Even patients who are AmeriHealth members may be employed by employers who offer more than one health plan and have open enrollment periods. Or, an employer may switch plans and force its employees into the new plan. Senior citizens covered by Medicare may be members of Medicare HMOs that are unrelated to any employment, and may be able to change plans freely. This fluidity explains why many physicians have contracted with a number of insurance companies. One PCP testified that he wanted to be signed up with as many HMOs as possible because he is afraid that his patients' employers may switch plans.

AmeriHealth has no direct financial interest in the physicians' practices, though, of course, AmeriHealth's success depends on recruiting and maintaining a broad network of physicians who can provide skilled and efficient medical care to AmeriHealth members. Around 40 percent of the physicians in the unit sought are solo practitioners, another 20 percent practice with one other physician, and the remaining 40 percent are part of group practices with numbers ranging from 3 to 17 physicians. Some of the physicians' practices are incorporated as professional corporations or associations, others operate as medical partnerships, and some are neither. There is also a wide variety of ownership arrangements. Some of the physicians are employees of their practices' corporations. The physicians establish and dissolve partnerships with other physicians and structure their practices without any input or involvement by AmeriHealth. They also affiliate and disaffiliate with hospitals without input from AmeriHealth, other than a requirement that each physician maintain admission privileges with at least one hospital that is a participating provider with AmeriHealth.

The physicians maintain the identity of their practices, and do business and advertise in their own names or the names of the group practices with which they are associated. AmeriHealth's name is included in only a few of the physicians' advertisements, and only among lists of other health insurance companies with whom the physician or the physician's practice has contracts. There is no evidence that physicians include AmeriHealth's name or insignia on their letterheads, business cards or prescription pads. Nor does AmeriHealth require that the physicians or their staffs wear AmeriHealth uniforms or display an AmeriHealth logo.

A little more than half the physicians' practices have only one location, another third have two locations, and the remainder have three or more locations. The physicians use a wide variety of equipment at their facilities, some of which involve large capital investment. Physicians are not required to have separate waiting rooms, offices or equipment for AmeriHealth members. The physicians choose their own facilities, office space and equipment and decide whether to own or lease them, design their own office layouts, and pay utilities and other overhead expenses. Other than AmeriHealth's basic facility and equipment requirements, discussed below, and AmeriHealth's requirement that physicians report changes in locations, AmeriHealth has no involvement in the physicians' decisions about their facilities or equipment. The physicians are free to expand the kinds of services they offer at their facilities. One PCP who testified at the hearing also practices sports medicine, and has added a "physical modalities therapy" unit to his office. Another physician witness who practices general and vascular surgery has added a "vascular lab" where he can conduct diagnostic tests on his patients rather than referring them elsewhere for the services. The physicians also arrange and pay for their own malpractice insurance, though this is required not just by AmeriHealth but by New Jersey law. (N.J.A.C. 8:38–15.2(b)8)

Physicians do not work at facilities owned or operated by AmeriHealth, and do not account for their hours of work to AmeriHealth. Other than requiring, as described below, that the physicians' practices have certain minimum numbers of office hours a week (depending on practice size and specialty), and requiring that they be open for one evening or weekend session per week, AmeriHealth is not involved in how the physicians set their working hours.

Nearly all of the physicians' practices employ staff other than physicians, such as nurse practitioners, RNs, LPNs, and other technical employees, medical assistants, receptionists, secretaries, office managers, and billing managers. Staff sizes and job duties vary widely among the practices. The physicians or their practices hire, fire, train, and supervise their staff, they define staff duties, and set compensation and benefits. While physicians have felt the need to hire additional clerical staff in recent years to handle administrative work resulting from their affiliation with AmeriHealth and other HMOs, AmeriHealth has no involvement in determining the number, identity, duties, supervision or compensation of the physicians' staffs. According to the Physician Managed Care Agreement, physicians are prohibited from assigning to others their "duties, rights or interests under the Agreement." However, physicians routinely delegate services, such as taking patient medical histories, measurements, and vital signs, and performing throat cultures, to staff members such as nurses and medical assistants.

The physicians are free to make other business decisions that affect their practices' profits or losses. Physicians set their own accounting methods, use payroll and billing services, and retain accountants, lawyers, and other business consultants. They choose how to invest or spend practice profits, and determine what portion of the practice revenues will be paid to the physicians. Among the practices of the six physicians who testified at the hearing, there were large differences in total practice revenues, physician compensation (ranging from $115,000 to $442,000 in 1997), and the portion of practice revenues that were paid out as physician compensation. The figures introduced into evidence, however, were those for the entire practices, and do not reflect profit and loss from the physicians' work for AmeriHealth.

Credentialing and Recredentialing Procedures and Standards

AmeriHealth does not train its physician providers to become medical doctors, recruit them out of medical school, or assist them in establishing medical practices. Rather, it recruits existing medical practices into its network of providers. AmeriHealth identifies practices to recruit from the yellow pages, medical staff lists from participating hospitals, other insurance carriers' lists of physicians, medical society membership lists, and recommendations from physicians or members. Physicians also approach AmeriHealth about affiliation.

Physicians must be "credentialed" before they may become a provider. In practice, AmeriHealth "credentials" and accepts 95 percent or more of the physicians who apply. AmeriHealth requires that physicians fill out a standard "Provider Credentialing Application" form. Credentialing criteria include (1) an unrestricted license to practice medicine in New Jersey; (2) Board Certification in any claimed specialty, or appropriate substitute such as training or continuing medical education (CME) credits; (3) current Drug Enforcement Administration certification, when applicable; (4) current malpractice insurance coverage in compliance with minimum New Jersey requirements; (5) maintenance of staff privileges at a minimum of one AmeriHealth participating hospital; (6) 24 hour-a-day, 7 day-a-week coverage for AmeriHealth members by the applying physician or another participating physician; (7) disclosure of malpractice history, history of loss or restriction of license or privileges, felony convictions, illegal drug use, and any reasons for inability to practice medicine with reasonable skill and safety; (8) eligibility to receive payment under Medicare/Medicaid; and (9) provision of education, training and work history.

Credentialing applicants who are PCPs and high volume specialty physicians (OB-GYNs, orthopedists and cardiologists) also receive site visits from AmeriHealth. Less than half the physicians in the unit sought are PCPs or high volume specialty physicians. These visits are conducted by RNs who inspect the applicant's office and medical records. Physicians must receive "passing scores" on the inspections. If the physician's practice has multiple sites, AmeriHealth visits only one of them. The practice is reviewed to determine whether it meets the following standards:

- The physician sees no more than 4 patients (PCP) or 6 patients (specialty physicians) per hour.
- Routine visits are scheduled within 1 week, 2 weeks, or a month (depending on the kind of practice), complete physicals within 4 weeks, sick visits within 24 hours (PCPs) or 2 days (specialty physicians), and emergency visits immediately.
- Phone calls are recorded and retained either in the medical record or a daily log reviewed by a physician.
- A PCP's office maintains at least the following hours: one evening or weekend session per week, and a total of 20 hours per week for a solo practitioner, 30 hours per week for a dual practice, and 35 hours per week for a group practice. A specialty physician's office maintains at least one evening or weekend session per practice per week, and a minimum of 12 office hours per week.
- The office has arranged for coverage 24 hours a day, 7 days a week.
- The office has policies and procedures to ensure confidentiality and continuity of care (i.e., reminding patients to keep their appointments, dealing with patients who miss appointments or do not follow-up, and recalling patients who need follow-up treatment or preventive care).
- The office is handicapped accessible and has adequate parking, handicapped accessible patient rest rooms, a clean and safe waiting room, private treatment rooms, otoscopes and opthalmoscopes (and GYN tables and supplies for family practice sites), blood pressure cuffs in pediatric, medium and large sizes, thermometers, "general supplies," and clean walls and floors.
- The office follows certain safety practices, including that drugs, prescription pads and syringes are not patient accessible and biologicals/medications are stored in a refrigerator not containing food; has a system to monitor the use of controlled drugs; properly handles and disposes hazardous waste; has a fire extinguisher, marked fire exits and a written evacuation plan; keeps its corridors and rooms free of clutter and obstruction; has a procedure for cleaning, sterilizing and replacing equipment; has a system to comply with OSHA regulations; ensures preventive maintenance on equipment, and, if laboratory work is performed, that it is performed in a separate area; and has at least one staff person on duty during patient hours who is CPR certified.
- The office's records meet certain requirements: all pages in the patient's record show the full patient name or ID number, all entries are dated and signed/initialed by a physician, records are legible to someone other than the physician and staff, a separate problem list is completed for each patient, the presence or absence of allergies is prominently noted, the record contains past medical history (including serious accidents, operations and illnesses) and biographical and personal data, including a means of getting in touch with the patient, the record indicates smoking habits and alcohol and substance abuse, the physician initials consult summaries and lab and x-ray results, encounter forms show notation for a return visit or follow-up care, and there is a separate immunization record for both children and adults.

AmeriHealth "recredentials" all physician providers every 2 years by collecting essentially the same information that was collected in the initial credentialing application. In addition, physicians are required to submit evidence of 40 CME credits. AmeriHealth makes recredentialing site visits at least every 2 years to PCPs, OB/GYNs and other high volume specialists. Again, AmeriHealth requires that offices receiving site visits obtain passing scores on the site visit and medical record standards. Finally, physicians must have maintained an acceptable "profile" regarding malpractice history and maintenance of AmeriHealth's "Standards of Service," which, as discussed below, are almost identical to the credentialing site visit standards. A PCP must maintain an acceptable "Utilization Profile," which may include an evaluation of the PCP's utilization review scores, referral patterns, compliance with precertification requirements, admission rates, and emergency room utilization. A PCP must also pass audits of medical records, preventive services and diagnoses, and the PCP's member complaints and Subscriber Survey results are evaluated, with an expected "subscriber satisfaction" rating of 90 percent.

In practice, it appears that credentialing and recredentialing forms are often filled out by the physicians' staffs. In addition, the nurses who conduct site visits normally interact with the physicians' staff rather than the physicians themselves, and they do not observe the physicians at work.

Standards of Service, Treatment Guidelines, and Quality Management

AmeriHealth issues a Physician's Office Manual to all physicians, and the Physician Managed Care Agreements require that the physicians follow the Manual with respect to AmeriHealth members. The Manual sets forth detailed "Standards of Service," "Medical Record Guidelines," and "Site Standards"

that the physicians are expected to meet. These include the credentialing site visit standards listed above, along with additional standards such as a 30-minute maximum waiting time for patients, and a 30-minute maximum response time for after-hours phone calls for "urgent" problems.

For PCPs, the Manual sets forth "Wellness Visits Practice Guidelines" which "are a recommended schedule of wellness visits and are not a statement of benefits." PCPs are advised that the Guidelines are reviewed at least every 2 years, and if new "national Guidelines become available" then the PCPs should "adapt their practices according to nationally recognized Guidelines, without awaiting changes from the Plans." The Manual's current Wellness Guidelines state how often members should visit the PCP (e.g., annual visits from 11–18 years, visits every 3 years for ages 19–40), and, at each "wellness" visit, what information should be obtained, measurements taken (e.g., height, weight, blood pressure); immunizations, lab tests and screenings administered (e.g., cholesterol screening, tetanus/diphtheria booster); education or counseling given (e.g., nutrition; dental health; household and automobile safety; tobacco, drug and alcohol use; and regular physical activity); and specialized test referrals provided (e.g., mammography and sigmoidoscopy).

The Manual incorporates AmeriHealth's "Clinical Practice Guidelines," which are detailed, disease-specific guidelines for the treatment of several particular kinds of medical problems, including hypertension, asthma, congestive heart failure, cholesterol, HIV/AIDS, diabetes, and smoking. These Guidelines are all based on recommendations from recognized medical authorities. The Manual states that the Clinical Practice Guidelines "are presented as a basis from which individual treatment plans can be developed" and that "[v]ariation in application related to individual need and severity of illness is expected." However, in a 1998 letter to physicians about the hypertension and asthma guidelines, AmeriHealth stated that it would measure compliance with the guidelines in its annual medical record review.

The manual describes the "Purpose" of AmeriHealth's Quality Management Program as follows:

> The Quality Management Program for the Managed Care Products of AmeriHealth Health Plan, Inc. is designed to meet our customer's expectations of high quality, affordable health care. It is AmeriHealth's responsibility to assure that adequate health maintenance, appropriate treatment of illness and timeliness of clinical and administrative services meet those expectations and needs.
>
> Another important aspect of health is satisfaction with the services provided. In recognition of the valid assessments that customers can provide, the Quality Management Program will pro-actively seek customer feedback and include education in its improvement efforts.
>
> To achieve improved health outcomes and satisfaction with services, a continuous process of monitoring, evaluation and improvement is implemented.

The Manual adds that, "Contracting providers are required to participate in the AmeriHealth quality measurement and improvement activities."

The Manual's description of the quality management Program includes a "Clinical Research and Evaluation" function, which, inter alia, "assesses medical record documentation, provision of clinical care and continuity of care," and "conducts annual satisfaction surveys." Physicians are advised that they "must cooperate with the on-site medical review process and must provide medical records when requested." In a subsection entitled "Provider Improvement," the Manual states:

> This function monitors individual provider performance in member satisfaction, medical record quality, rates of complaints, occurrences and transfers and under and over utilization. Bi-annual reports are sent to participating providers. Interventions are targeted to improve performance when needed. Providers must respond to investigations of member complaints regarding quality of care and service. Providers are also required to cooperate with the development of action plans when measurements identify opportunities for improvement.

AmeriHealth's standard Physician Managed Care Agreement requires that physicians "cooperate with AmeriHealth HMO to facilitate the information and record exchanges necessary for Quality Management, Utilization Management, peer review, or other programs." Physicians must provide "reasonable access during regular business hours to specified clinical and medical records of Participants." "Upon reasonable notice at reasonable hours," the Agreement states, AmeriHealth "may inspect Physician's premises and operations to ensure that they are adequate to meet Participants' needs."

The office manual indicates that each PCP will receive an "annual performance review" from AmeriHealth. Every year, PCPs receive on-site visits from AmeriHealth nurses who audit their patient records for purposes of reviewing the practice's performance. First, AmeriHealth sends letters announcing that AmeriHealth is going to be conducting "the annual Primary Care Physician Medical Record Review" in order to "measure specific indicators that evaluate general record organization and preventive care." AmeriHealth provides a list of members "whose charts have been randomly selected for review." An AmeriHealth quality management nurse visits soon thereafter and reviews the selected patient charts. The visit normally takes several hours, an at the end the nurse conducts an exit interview which, according to AmeriHealth's record review notice letter, "provides a general overview of the findings and is intended as an educational tool to improve documentation." During these on-site record reviews, AmeriHealth's nurse generally deals with the physician's staff, and not the physician, and the nurse does not observe the physician treating patients.

Following the on-site record review, AmeriHealth sends the PCP an "Annual Primary Office Practice Quality Assessment Score (PQAS)." The PCP's summary PQAS is derived from office record reviews and member satisfaction surveys. The "General Medical Record Review" indicates what percentage of the patient records reviewed met AmeriHealth's medical record guidelines. In the "Preventive Care Delivery Review," AmeriHealth indicates the percentage of the charts reviewed which indicated that the PCP had taken the measurements, administered the screenings, given the counselings, and made the lifestyle assessments that are included in AmeriHealth's Wellness Guidelines. The primary care Delivery review does not cover all of the elements in the wellness guidelines. For example, the review does not cover the frequency of wellness visits. AmeriHealth General Manager Dr. Richard Gilfillan testified that AmeriHealth does not require strict adherence to the Guidelines' schedule for services, although physicians are

expected to provide the services "within time frames that are close" to the Guidelines. Finally, a "Member Satisfaction Survey" is conducted "by telephone in a stratified random sampling method, ensuring statistically significant results." The survey results provided to the PCP include scores for member responses to questions under the general headings of overall satisfaction, access, care, perceived access, and preventive service counseling.

AmeriHealth also regularly sends PCPs a separate "Provider Appraisal," which shows figures for "office waiting time" (the proportion of patients in the PCP's practice "who indicated waiting longer than 30 minutes for standard appointments, exceeding the Plan's practice site standards"), the number of member complaints and the "complaint rate," the number of patient transfers away from the PCP and the "transfer rate," and summary scores for the office record review and the member satisfaction survey. On the appraisal, each of these results is compared to a "mean" score for all PCPs in the network.

AmeriHealth's cover letter to PCPs accompanying the PQAS results states, "The results of the ORR [Office Record Review] and MSS [Member Satisfaction Survey] will be reviewed annually and may affect your continued participation with AmeriHealth." AmeriHealth admits that it considers this information in the recredentialing process, and indeed the office manual advises physicians that the purpose of recredentialing is, among other things, "to evaluate physician compliance with guidelines and processes of the Plans and to assess customer satisfaction with the provider." There is no evidence, however, AmeriHealth has ever terminated a physician's participation in the network because of poor office record review results or low numbers on member satisfaction surveys, or for failure to follow the Manual's Wellness Guidelines or Clinical Practice Guidelines. Nor does AmeriHealth impose any kind of financial penalties related to these performance reviews. On the other hand, there is evidence that negative performance reviews generate corrective action. AmeriHealth talks with physicians who receive low scores on the record review or the member satisfaction survey and request a plan to improve performance (an "action plan"). If they still do not improve, then there is the possibility that AmeriHealth would cancel the contract.

The Office Manual's standards of service and site standards apply to specialty physicians as well as PCPs, as do the Manual's and the Physician Managed Care Agreements' provisions on recordkeeping, access and inspection privileges. There is no evidence, though, that AmeriHealth has conducted performance reviews or appraisals of specialty physicians.

AmeriHealth obtains patient chart information from physicians on a regular basis for planwide surveys required by the National Committee for Quality Assurance (NCQA) (see discussion below) and the State of New Jersey. Under NCQA's Health Plan Employer Data and Information Set (HEDIS) guidelines, AmeriHealth collects data on a randomly selected set of patients. In 1996 and 1997, AmeriHealth apparently used the HEDIS chart review information for performance evaluations of individual physicians. However, in its 1998 HEDIS chart review, AmeriHealth assured the physicians that the HEDIS chart review was for planwide measurements (i.e., the plan's overall compliance with NCQA standards) and not for individual provider evaluations. AmeriHealth performs similar chart reviews to monitor planwide compliance with AmeriHealth's disease-specific Clinical Practice Guidelines. AmeriHealth also actively promotes compliance with these guidelines by, for example, sending out letters to patients and their physicians that encourage patient visits to their physicians to receive a particular screening or commence a particular program of treatment.

As noted above, AmeriHealth's Physician Managed Care Agreement requires that physicians provide services to members "with the same standard of care, skill and diligence customarily used by similar physicians in the community in which such services are rendered." In practice, AmeriHealth does not control or monitor the manner in which physicians perform procedures on patients. Its representatives do not observe the physicians as they work, or listen to their conversations with patients, or direct the physicians in the details of how they perform the procedures. In fact, the physicians may go years without meeting an AmeriHealth representative.

On the other hand, the physicians must provide AmeriHealth with records showing much or all of the work they perform for AmeriHealth members. Specialty physicians must submit an AmeriHealth "Encounter/Referral form" along with an itemized bill in order to receive payment for services. AmeriHealth also requires that PCPs provide "encounter data on a timely basis [within 60 days] showing all services provided to each Participant for whom Physician receives Capitation or Fee for Service payments." In practice, PCPs fill out and submit a copy of AmeriHealth's "Encounter/Referral form" for each member visit. The form indicates, inter alia, the type of visit, whether it is a "Wellness Visit," if any acute or chronic illness was involved, what kind of followup is required, and what kind of immunization was administered.

Physician witnesses at the hearing testified that they attempt to follow the Manual in their dealings with AmeriHealth members, but do not necessarily consult the Manual themselves. Instead, they may rely on their office staffs to inform them of AmeriHealth's unique guidelines and procedures. Many of the Manual's requirements are standard practices that physicians routinely follow for all of their patients, both AmeriHealth members and nonmembers.

Utilization Management

AmeriHealth's utilization management program is called Patient Care Management. AmeriHealth's Office Manual describes the program as follows:

> The Patient Care Management program is composed of several component programs, all of which are focused on ensuring a balance of quality, access, and cost containment. The focus is on directing providers and members to use the most appropriate site and level of care. This is best accomplished through intervention by the Patient Care Management team before services are rendered. Therefore, wherever possible, programs are structured for prospective review.
>
> . . . .
>
> The Patient Care Management philosophy is member focused. The use of clinically credible medical appropriateness criteria and clinical standards for all key processes encourages high-quality care and enables the Patient Care Management Department to direct our members to the most appropriate level of care.

AmeriHealth's Patient Care Management Department's "prospective review" procedures include precertification, concurrent review, discharge planning, and episodic case management. AmeriHealth engages in retrospective review of provider

decisions when it reviews their bills and decides whether to pay them. Through these procedures, AmeriHealth directs providers and members to the "the most appropriate site and level of care."

Under AmeriHealth's program, the "appropriate site" of care is, in the first instance, the member's designated PCP. With only a few exceptions (e.g., routine OB/GYN care for women, emergencies), a member must obtain a referral from his or her PCP before receiving services from other health care providers. Absent prior authorization from AmeriHealth, i.e., precertification, the PCP's referrals are limited to network providers. Specialty physicians must have a referral before performing services, and are limited to the services indicated on the PCP's referral. If the member then needs additional services beyond those specified in the referral, the member or the specialty physician must go back to the PCP for another referral.

AmeriHealth requires that certain outpatient services, such as most radiological procedures, laboratory work, mental health services and short-term rehabilitation therapy, be performed by particular "capitated" providers. Precertification is required, and usually not granted, for such services at providers other than the "capitated sites." For outpatient diagnostic radiology, referrals must be to Radiology Consultants of New Jersey (RADCON), a local network of radiology groups in southern New Jersey which includes several physicians in the unit sought. Short-term outpatient rehabilitation therapy and laboratory work must also be referred to "capitated" sites which are selected by each PCP from a list of network providers, and thereafter the PCP must refer members to the PCP's designated capitated site for such services, or obtain precertification for referral anywhere else. Mental health and substance abuse services must be referred to Green Spring of Eastern Pennsylvania, which operates its own network of providers.

Physicians must refer patients to the capitated sites for radiology, laboratory work, or physical therapy even if they have the equipment in their own offices to perform the service, or believe it would be in a patient's best interest to perform the service at the physician's office or at a facility other than the capitated site. As a result, physicians have, in some cases, simply performed such services in their own office without reimbursement. At the hearing, a PCP who also ordinarily provides mental health care to his own patients testified that he cannot do so for AmeriHealth patients, unless the patient is willing to pay for the services outside their insurance coverage or he is willing to provide the services for free, even though Green Spring of Pennsylvania's network is limited in New Jersey and may require a long trip for the patients.

AmeriHealth's Patient Care Management program controls the "level of care" for its members through application of the contractual limitation of "covered services" to those that are "medically necessary." The Member Handbook defines the "medical necessity" as follows:

[T]he requirement that Covered Services or medical supplies are needed, in the opinion of: (a) the Primary Care Physician; (b) the Referred Specialist; and/or (c) AmeriHealth HMO and:

> A. are consistent with AmeriHealth HMO policies, coverage requirements and utilization guidelines;
> B. are necessary in order to diagnose and/or treat a Member's illness or injury;
> C. are provided in accordance with accepted standards of American medical practice;
> D. are essential to improve the Member's net health outcome and may be as beneficial as any established alternatives;
> E. are as cost-effective as any established alternative; and
> F. are not solely for the Member's convenience, or the convenience of the Member's family or health care Provider.

AmeriHealth's finding that any one of these requirements has not been met could lead to a determination that a service is not "medically necessary" or "medically appropriate."

The Patient Care Management Department's concurrent review process determines how long AmeriHealth will cover a patient's stay in a hospital or other treatment facility, or what level of care will be covered. AmeriHealth performs on-site and tlephonic review, in coordination with hospital utilization review personnel, "to certify elective, urgent, and emergency admissions, to authorize admission or continued stay beyond the expected length of stay, to assess the level of care, and to identify and coordinate discharge planning." AmeriHealth has exercised concurrent review so as deny coverage for additional hospital days as not "medically necessary," notwithstanding the treating physician's judgment that continued hospital treatment would be best for the patient. AmeriHealth has also exercised this review so as to deny payment to a hospital for days of a patient's hospitalization, or deny payment to physicians for services they performed in the hospital, after services have been rendered, because "medical appropriateness could not be established."

In discharge planning, AmeriHealth reviews and approves the level of care a patient receives following discharge from inpatient admissions. In episodic case management, AmeriHealth designs plans to provide services "in an alternative setting for patients who otherwise would require continued hospital care" by early identification of such cases, and coordinating resources among the patient's family, involved health care professionals, and the community.

AmeriHealth's most frequently exercised form of utilization review is precertification. AmeriHealth determines, through its precertification procedure, whether the requested services are "covered services," and where they must be provided in order for AmeriHealth to cover them. AmeriHealth requires precertification for the following:

- All non-emergency inpatient services, whether at a hospital, skilled nursing facility, rehabilitation facility, or a mental health/substance abuse facility, and all hospital short procedures unit or ambulatory services, including outpatient surgeries
- All procedures at "free-standing facilities" (i.e., surgical centers or reproductive health centers), except terminations of pregnancies
- Durable medical equipment or supplies that are purchased for $100 or more, or are rented for any price
- Prosthetics and orthotics
- Outpatient therapy services, including speech, occupational, cardiac, respiratory and pulmonary therapies or re-

habilitation, and infusion therapy (e.g. chemotherapy) at hospitals, homes or cancer centers (but not in a physician's office)
- Home care of any kind
- Hospice care
- Out-of-network referrals
- Minor surgeries (such as bunionectomies, hemorrhoidectomies, arthroscopic knee surgeries and diagnostic arthroscopy, and tonsillectomies)
- Sleep studies
- Selected laboratory or radiological tests, including CT scans, MRIs, MRAs, and PET (positron emission tomography) scans
- Sigmoidoscopies (unless performed in a physician's office)
- Certain medications
- Obstetrical care
- Chiropractic care

Almost all services provided by specialty physicians require a referral from a PCP, but only those listed above require precertification. PCPs may provide "primary care covered services" without precertification. According to AmeriHealth's standard, "HMO Primary Care Physician Program Attachment," these services include "office visits, phone and urgent care, home and Emergency care, periodic health assessments, adult EKG's, minor surgical and diagnostic procedures in office, immunization and injections, vision and hearing screening and laboratory screening procedures for assessment of acute illness and impatient hospital visits." According to the same Attachment, other procedures paid by fee for service require prior authorization. It appears, however, that AmeriHealth's Office Manual generally authorizes a number of procedures commonly provided by PCPs, and that PCPs need not obtain precertification for such procedures in order to obtain reimbursement.

Only a small portion of the procedures performed by PCPs require precertification. According to AmeriHealth General Manager Dr. Richard Gilfillan, for every 1000 members, there are, on average, about 35 nonemergency hospital admissions and 40 hospital outpatient surgeries each year that require precertification, while those same 1000 members will visit network physicians about seven times a year each (i.e., for about 7000 visits). There is no evidence in the record about the frequency of the other services listed above that require certification, but it appears that most services received by members in any given year do not require precertification. However, AmeriHealth is free to change its precertification requirements, and the list of services requiring precertification has changed from time to time. Whether a procedure requires precertification may depend on where the procedure is to be performed, or on what part of the body the screen or test is to be administered. Physician office staff are also faced with different sets of rules for patients with different health insurers, each of which may have its own provider manual and unique precertification requirements. Record evidence suggests that network physicians or their staffs are often unsure of whether precertification is required, and sometimes contact AmeriHealth's Patient Care Management Department for approval of services where, in fact, no precertification is necessary.

The process of precertification normally involves a phone call from the physician's office to AmeriHealth's Patient Care Management department. The calls are initially answered by "managed care assistants" who verify the patient's eligibility to receive Plan benefits. If the procedure requires precertification, the managed care assistant obtains information about the physician's diagnosis and the requested service. Managed care assistants generally have no medical training and can only approve or precertify a few minor procedures or tests. All other requests are referred to "patient care coordinators," most of whom are nurses. Patient care coordinators obtain more information from the physician's office, including, on occasion, faxed copies of the patient's chart. They then use a computer program called the Optimed Medical Appropriateness Screening Criteria to determine whether a precertification request should be granted. If the request meets the Optimed criteria, then the patient care coordinator grants the request. If not, the request is referred to one of AmeriHealth's Medical Directors, all of whom are physicians. The Medical Director may grant or deny the request. Neither managed care assistants nor patient care coordinators have authority to deny a request. However, a patient care coordinator may refuse to precertify a procedure because the patient is not a member, or the caller has provided insufficient information, or because the service does not require precertification. While the record does not indicate precise numbers for precertification requests and denials, an AmeriHealth patient care coordinator testified that AmeriHealth approves about 95 percent of the precertification requests she handles.

If the Medical Director denies the request, the member or requesting physician can speak directly with the Medical Director by way of an immediate appeal. If that appeal is denied, then either the physician or member may invoke a formal internal appeals process. In the past year, there were fewer than ten formal appeals of precertification denials. The record does not indicate the frequency of immediate informal appeals by physicians to the Medical Director, but suggests that such appeals are far more common than formal appeals. Following the denial of a formal appeal, a member may request external review through an independent utilization review organization.

Calls to AmeriHealth for precertification are normally made by the physician's staff, and not by the physician. The volume of calls from physicians' offices to the Patient Care Management department is high. Each managed care assistant handles a minimum of 68 calls a day and may average 100 calls a day, and patient care coordinators receive about 70 calls a day from provider offices and make an additional 25 return calls. Conversations with managed care assistants and patient care coordinators are normally only a few minutes each, but physician staff who call for certification often have to wait while their calls are routed to the appropriate desk, or for patient care coordinators to return phone messages. Each request may involve several phone conversations. Physician staff testified that precertification requests each take 20 or 25 minutes of phone time. As noted above, physicians and staff testified that time-consuming referral and precertification procedures required by HMOs have made it necessary for their practices to hire more clericals.

Some of AmeriHealth's denials of coverage, either by refusing to precertify a service or refusing to reimburse a provider for a service already rendered, are because the service was not performed at a preferred site (e.g., the "capitated" site for radiology), or because of a procedural error (e.g., failure to obtain a referral or precertification). Other denials are based on Ameri-

Health's determination that, contrary to the member's physician, the service was not "medically necessary." Thus, for example, AmeriHealth denied a PCP's precertification request for chiropractic therapy for one of the physician's patients on the basis that "medical necessity could not be established." AmeriHealth denied another physician's precertification request for acute inpatient rehabilitation for the same reason. Physicians testified that when patients came to them with soft-tissue injuries in knees, elbows, shoulders or muscles, the physicians have requested precertification for MRIs, but AmeriHealth denied the requests because the patients had not first received x-rays. The physicians considered x-rays to be an unnecessary waste of time and potentially harmful to the patients because appropriate treatment was delayed.

AmeriHealth also may withhold precertification for treatments it views as "experimental." For example, physicians have recently sought to test for the presence of H. Pylori bacteria, a cause of gastric ulcers, using a new FDA-approved urea breath test rather than an endoscopy with biopsy, which is more invasive, less reliable and more expensive than the breath test, and which requires sedation for a day or more that leaves the patient feeling drowsy. As of the hearing, AmeriHealth had not decided whether the breath test procedure is a "covered service," and therefore the physicians have been unable either to obtain precertification and reimbursement from AmeriHealth or to bill patients directly for the procedure.

AmeriHealth points out that its Patient Care Management utilization rules do not control the physicians' medical care decisions, only AmeriHealth's "coverage" for decisions. According to the Physician Managed Care Agreement, "Nothing in this Agreement, including Physician's participation in the Quality Management and Utilization Management process, shall be construed to interfere with or in any way affect Physician's obligation to exercise independent medical judgment in rendering health care services to Participants." If a physician believes that it is in the patient's best interest to receive services at a site that is not approved by AmeriHealth, or receive services that AmeriHealth has decided are not "medically necessary," the patient is free to follow the physician's recommendation, but AmeriHealth will not pay for the services. AmeriHealth provides physicians with a form entitled "Member Consent for Financial Responsibility for Unreferred/Non-Covered Services."

The Physician Managed Care Agreements provide that the physicians "shall cooperate with any formulary adopted by AmeriHealth HMO and HMO Program Requirements regarding the substitution of generic pharmaceuticals." AmeriHealth gives all physicians a "Prescription Drug Formulary," which applies to medications dispensed to outpatients by participating pharmacies (but not to inpatient medications or medications obtained from, or administered by, the physicians themselves). The Formulary is designed to "substantially reduce costs associated with [AmeriHealth's] prescription program." According to the Formulary:

> Physicians are expected to comply with the Drug Formulary when prescribing medications for participants. If a pharmacist receives a prescription for a non-formulary medication, the pharmacist is expected to contact the physician to request a change to a formulary product. If the physician is unwilling to change, or is unavailable, the pharmacist will dispense the prescription as written and record the results of the call. The P&T Committee [AmeriHealth's Pharmacy and Therapeutics Committee] will monitor prescriptions written and dispensed in non-conformance with the formulary and communicate with physicians to encourage better compliance with formulary products.

The Formulary lists drugs by category, and indicates the relative cost of the drugs within each category. For a number of specified non-formulary medications, the Formulary designates "brand interchange drugs" which "produce similar therapeutic effects" as the non-formulary medications but not necessarily the same effects. With respect to other medications, the Formulary directs physicians use a generic equivalent. Certain medications also require prior authorization, in which case the physician must provide AmeriHealth with patient clinical information. At the hearing, physicians testified that AmeriHealth's Formulary did not include certain drugs that they believed were more effective than the Formulary drugs, and that certain dosage limitations in the Formulary are too low for some patients. If a physician prescribes a medication not on the Formulary, or prescribes a name-brand medication rather than a generic equivalent, or prescribes a dosage above the limit indicated in the Formulary, the member may get the prescription filled at a pharmacy, but may have a higher copay or have pay the difference between the cost of the prescribed medication and the cost of the medication authorized by the Formulary.

According to AmeriHealth's "Patient Care Management 1998 Program Description," AmeriHealth uses "Medco" as its "Pharmacy Benefit Management Company." In August 1998, two physicians received similar mailings from Merck-Medco Managed Care, which identified itself as the manager for AmeriHealth's drug benefit program. The letters questioned the physicians' continued prescription of Pepcid, a drug used to treat ulcers, and recommended a different therapy "as a means to eliminate the need" for the use of Pepcid. The Merck-Medco letters included "response forms" on which the physicians were expected to indicate either their agreement with the recommendation or their reasons for continuing the Pepcid treatment. One physician testified that he receives such letters regularly, and when he does he reviews the relevant patient chart to determine whether Merck-Medco's recommendation are appropriate, but he follows the recommendation only 10 percent of the time. Another physician's billing manager testified that when her office receives such mailings, the physician's office responds by requesting a fee for the physician to review the patient's medical records, and that Merck-Medco never pays the fee and the physician never performs the review. The record does not indicate whether AmeriHealth has taken any action against physicians for failing to adhere to the Formulary or follow Merck-Medco's recommendations.

State Regulation

New Jersey law requires that HMOs "establish and implement a comprehensive utilization management program to monitor access to and appropriate utilization of health care and services" (N.J.A.C. 8:38–8.1(a)), and that provider contracts specify that providers "shall comply with the HMO's quality assurance and utilization review programs." (N.J.A.C. 8:38–15.2(b)7) For the most part, New Jersey law does not dictate HMOs' treatment policies, protocols, quality assurance activities or utilization management decisions, but only requires that they be "based on generally accepted standards of health care practice." (N.J.S.A. 26:2S–6a)

New Jersey law requires that HMOs have credentialing, "recertification" and performance review procedures, but does not specify the content of these procedures or the standards they apply, other than the physicians have certain training and licensing qualifications. (N.J.A.C. 8:38–4.2) State law requires that HMOs provide "basic health care services," but these refer to general areas of required coverage and several particular preventive care services (N.J.A.C. 8:38–5.1 et seq.; N.J.S.A. 26:2J–4.3a,–4.4,–4.6), and do not include the range or level of health care services AmeriHealth assures its members and includes in its Wellness Guidelines and Clinical Practice Guidelines. The State sets minimum requirements for PCP availability that are echoed in AmeriHealth's Standard of Service, i.e., that the HMO and PCPs assume "mutual responsibility" to ensure emergency and urgent care for members 24 hours a day, seven days a week and that emergency care be provided immediately, that urgent care be provided within 24 hours, and that routine appointments be scheduled within 2 weeks. (N.J.A.C. 8:38–6.2, -15.2(c)2) In most other respects, AmeriHealth's Standards of Service and Site Standards are more stringent than those mandated by State law. The State also requires that HMOs have a "system-wide continuous quality improvement program" which includes "specifications of standards of care, criteria and procedures for the assessment of the quality of services provided and the adequacy and appropriateness of health care resources utilized," but does not dictate what the standards, criteria or procedures must be. (N.J.A.C. 8:38–7.1(a)6) State law requires, as part of the "continuous quality improvement program," that an HMO have "a mechanism for evaluating all providers," but does not mandate the elements of AmeriHealth's performance appraisals for PCPs. With respect to utilization management, New Jersey law requires that any "utilization management decision" to deny coverage because the service is "not medically necessary" must be made by a physician and be based on written clinical criteria and protocols and generally accepted medical standards. New Jersey does not, however, require that an HMO precertify procedures, or deny coverage if its judgment of "medical necessity" differs from a provider's judgment. (N.J.S.A. 26:2S–6; N.J.A.C. 8:38–8.1,–8.3)

Many of AmeriHealth's quality assurance and utilization management rules, procedures and standards are derived from those recommended by the National Committee for Quality Assurance (NCQA). Contrary to AmeriHealth, though, New Jersey does not require that AmeriHealth meet NCQA's standards. NCQA is a private organization created by the managed care industry in an attempt at self-regulation. Its mission is "to provide information to purchasers and consumers of managed health care to distinguish among plans based on quality, thereby allowing them to make more informed health care purchasing decisions." New Jersey's Department of Health requires that each HMO undergo a "comprehensive assessment review" every 3 years. (N.J.A.C. 8:38-2.4) As part of that triennial review, the HMO must submit evidence of its most recent "external quality audit" by an "external quality review organization" approved by the State. If the HMO receives accreditation by the external quality review organization, then the HMO is exempted from examination by the Department of Health in any area where the review organization's audit demonstrated substantial compliance with New Jersey's standards. (N.J.A.C. 8:38-7.2) In fact, NCQA's standards are far more comprehensive and stringent than New Jersey's standards. AmeriHealth has chosen to be audited by NCQA and to submit that audit to meet the State's requirement, but AmeriHealth is not required to select NCQA as its auditor. Similarly, AmeriHealth may avoid examination by the Department of Health by meeting NCQA's standards and obtaining NCQA's accreditation, but again, it is not required to do so.

Negotiability of Contract Terms

AmeriHealth offers the same standard Physician Managed Care Agreement, with Program Attachments and Addendums, to all physicians. AmeriHealth agrees to language modifications in only 2 to 5 percent of its Agreements with physicians, and then only to modifications in certain provisions of the Agreement. The only example AmeriHealth provided of an Agreement where a physician successfully negotiated modified language was an Agreement with an OB/GYN specialty physician in a geographic area where there are few such specialists. There is no evidence that AmeriHealth has negotiated with individual physicians over its capitation rates, and in fact these rates are set forth in the Office Manual. AmeriHealth offers and generally obtains agreement to its standard fee for service schedules, but may enter into "special pricing arrangements." As of mid-1998 when AmeriHealth implemented significant changes in its fee schedule, only about 10 percent of the physicians in southern New Jersey had a "special pricing arrangement." These enhanced prices may only apply to a few of the procedures that a "special price" recipient performs. AmeriHealth grants these arrangements where it believes that it needs to have a particular physician or group of physicians in the network. AmeriHealth Provider Relations Vice President Glenn Chong testified that AmeriHealth never refuses to discuss fees with a physician. Physicians and their staff testified that they felt unable to negotiate over contracts or fees with AmeriHealth because the terms were presented to them by AmeriHealth representatives as nonnegotiable, but the record is unclear as to what efforts these physicians or their staffs made to negotiate.

AmeriHealth's standard Physician Managed Care Agreement limits the physicians' ability to negotiate prices by limiting the information available to them about what AmeriHealth pays other physicians. According to the Agreement, "Physician agrees to maintain the confidentiality of all information related to fees, charges, expenses and utilization derived from, through, or provided by AmeriHealth." When one physician sought to negotiate over fees and asked Provider Relations Vice President Chong whether AmeriHealth's offer to him was consistent with other offers AmeriHealth had made, Chong replied that he "was not at liberty to talk about that" because "fees are a private matter."

According to AmeriHealth's standard Physician Managed Care Agreements, AmeriHealth promises to reimburse physicians for fee for service care based on AmeriHealth's fee schedule "in effect" at the time of the service. AmeriHealth's fee schedules are subject to unilateral modification. At the end of May 1998, AmeriHealth announced to 90 percent of the unit physicians, i.e., those who did not have "special pricing" fee arrangements, that a new fee schedule would be effective on July 1, 1998. Some of the new fees were higher, but many were substantially lower than the pre-July 1998 fees. One set of "sample fees" for general surgery and vascular surgery showed reductions for all but two of the procedures listed, and the fee reductions ranged as high as $476. For example,

AmeriHealth's reimbursements for various bypass grafts were all reduced, with the reductions ranging from 8 to 31 percent.

The record revealed four instances where physicians obtained from AmeriHealth offers to make changes to the July 1998 fee schedule, though the record does not indicate how significant those changes were. One surgeon responded to the new rates by sending a notice of termination. AmeriHealth replied by making him an offer that varied from the new fee schedule. The surgeon made efforts to negotiate higher rates by, among other things, demanding the same "special pricing" fee schedule paid to another local physician, but AmeriHealth refused. The surgeon ultimately agreed to AmeriHealth's offer. One OB/GYN specialty physician was granted fee revisions for 10 procedures. Another specialty physician received an offer to revise the new fees for certain procedures and patients, but the physician's practice group rejected the offer and terminated its relationship with AmeriHealth. Yet another physician's practice objected to AmeriHealth that the newly imposed fee schedule was "below Medicare rates." AmeriHealth responded with an offer to increase the fee schedule to "Medicare rates."

Discussion

Section 2(3) of the Act provides that the term "employee" shall not include "any individual having the status of an independent contractor." Recently, in *Roadway Package System*, 326 NLRB 842 (1998), the Board reexamined the test for determining whether an individual is an employee or an independent contractor. The Board observed that the Supreme Court in *NLRB v. United Insurance Co. of America*, 390 U.S. 254 (1968); *Community for Creative Non-Violence v. Reid*, 490 U.S. 730 (1989); *Nationwide Mutual Insurance Co. v. Darden*, 503 U.S. 318 (1992); and *NLRB v. Town & Country Electric*, 516 U.S. 85 (1995), applied the traditional common law of agency standard, and the Board concluded that it had no authority to apply a different one. The multifactor common-law analysis, articulated in terms of masters and servants, is set forth in the Restatement (Second) of Agency, Section 220, pp. 485–486 (1958):

> (1) A servant is a person employed to perform services in the affairs of another and who with respect to the physical conduct in the performance of the services is subject to the other's control or right to control.
>
> (2) In determining whether one acting for another is a servant or an independent contractor, the following matters of fact, among others, are considered:
>
> (a) the extent of control which, by the agreement, the master may exercise over the details of the work;
>
> (b) whether or not the one employed is engaged in a distinct occupation or business;
>
> (c) the kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision;
>
> (d) the skill required in the particular occupation;
>
> (e) whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work;
>
> (f) the length of time for which the person is employed;
>
> (g) the method of payment, whether by the time or by the job;
>
> (h) whether or not the work is a part of the regular business of the employer;
>
> (i) whether or not the parties believe they are creating the relation of master and servant; and
>
> (j) whether the principal is or is not in business.

The Board in *Roadway Package System* rejected the argument that the predominant factor in the analysis is whether an employer has a "right to control" the manner and means of the work performed by the individual whose status is at issue:

> While we recognize that the common-law agency test described by the Restatement ultimately assesses the amount or degree of control exercised by an employing entity over an individual, we find insufficient basis for the proposition that those factors which do not include the concept of "control" are insignificant when compared to those that do.

Roadway Package System, supra, 326 NLRB 842, 850 (1998). Noting that the Restatement factors are not exclusive, and specifically permit the consideration of other relevant factors, the Board stated that the test "encompasses a careful examination of all factors and not just those that involve a right of control." In summary, the Board held that "in determining the distinction between an employee and an independent contractor under Section 2(3) of the Act, we shall apply the common-law agency test and consider all the incidents of the individual's relationship to the employing entity." Id.

The Board's application of this test is often difficult, and is complicated by the fact that, as noted by the Restatement's drafters, the policies underlying employment-related statutes such as the Act "have not much in common with the policies underlying the rules" of common-law agency. Restatement, supra at § 3. The language of Section 2(3) expressly excluding "independent contractors" from the Act's protections was added by amendment in the 1947 Labor Management Relations Act (the Taft-Hartley Act) because Congress disagreed with the broader definition of "employee" applied by the Board and Supreme Court in *NLRB v. Hearst Publications*, 322 U.S. 111, 126 (1944). In that case, the Court held that the standard should be consistent with the Act's purposes "to encourage collective bargaining and to remedy the individual worker's inequality of bargaining power" by protecting the exercise of freedom of association, self-organization, and designation of representatives. Subsequently, the Court held in *NLRB v. United Insurance Co*., supra, 390 U.S. at 256, that the Taft-Hartley amendment mandated application of the narrower common-law definition. In contrast to the labor policy-related standard applied in *Hearst Publications*, the common-law rules of masters and servants are concerned with tort liability. The relation of master and servant is a particular form of agency, which the Restatement addresses in order to set forth the unique liability of a master for harm caused to third persons by the tort of a servant, and the special tort-related duties and immunities between masters and servants. Restatement, supra at §13, 479–480, 480–481. The Restatement distinguishes between servants, who are a kind of agent, and independent contractors, who may or may not be agents and to whom the tort rules of masters and servants do not apply. Id. at § 12–14.

Thus, the legal issue presented in the instant case is not whether collective bargaining by the unit physicians would benefit them or their patients, or whether "inequality in bargaining power," if it exists, between the physicians and AmeriHealth could be remedied by the Act's protections. Nor is the

issue whether the physicians have become agents of AmeriHealth in its efforts to control health care costs. Rather, the issue is whether the physicians, in their work for AmeriHealth, are so integrated with and controlled by AmeriHealth that they meet the statutory definition of employees which, in turn, is based on the common-law definition of "servants."

The Board's recent decisions in *Roadway Package System* and *Dial-A-Mattress Operating Corp.*, 326 NLRB 884 (1998), which issued the same day, addressed the status of pickup and delivery drivers and owner-operators, questions the Board has faced in numerous cases over the years. As the Board noted in its Decision on Review, in the instant case, "the issue of the relationship between physicians and HMOs is raised for the first time." While it may seem anomalous to consider whether a licensed and practicing medical doctor could possibly meet the definition of a "servant," the Restatement cautions against drawing conclusions from the everyday use of the term:

> As stated more fully in Section 220, the term servant does not denote menial or manual service. Many servants perform exacting work requiring intelligence rather than muscle. Thus the officers of a corporation or a ship, the interne in a hospital, all of whom give their time to their employers, are servants equally with the janitor and others performing manual labor. [Restatement, supra at § 14.]
>
> The definition of servants [in the Restatement] is based on the theory that they are a particular kind of agent; . . . that persons who are doing things for others are servants if there is the very close economic relation and control described in this Section; and, that this is true whether or not the persons are primarily engaged to do manual work or to make contracts. Indeed, fully employed but highly placed employees of a corporation, such as presidents and general managers, are not less servants because they are not controlled in their day-to-day work by other human beings. Their physical activities are controlled by their sense of obligation to devote their time and energies to the interests of the enterprise. [Id. at 478–479]

In its Decision on Review in the instant case, the Board noted that "[t]he physicians working with HMOs maintain their own offices and staffs and are not 'as obviously employees as are production workers in a factory,'" but that "the HMOs place certain conditions and restrictions on the physicians which indicate that they do not have the independence normally associated with an independent contractor." The Board expressed particular interest in the development of a record on the extent to which HMOs control "the physicians' delivery of health care services and access to patients."

The record establishes that AmeriHealth controls, or has the right to control, many details of the services the physicians deliver to AmeriHealth members pursuant to the physicians' contractual relationships with AmeriHealth. See Restatement, supra, Section 220(2)(a). To begin with, the physicians must accept and treat AmeriHealth members who select the physicians or are referred to them. Though PCPs can opt to limit their panel size after it reaches a minimum of 150, they must continue treating the AmeriHealth patients they have. As the Physicians Managed Care Agreement automatically renews each year, a physician's obligation to treat AmeriHealth patients continues indefinitely, until either party terminates the Agreement. See Restatement, Section 220(2)(f). AmeriHealth has only rarely terminated Agreements. The record does not indicate how often physicians terminate Agreements, but suggests that they are generally unwilling to do so for fear of losing their AmeriHealth patients.

In providing services to AmeriHealth members, the physicians are required to adhere to detailed standards of service and site standards for their office facilities, equipment, accessibility, safety practices and recordkeeping. Some of these standards appear to be State-mandated minimums or generally-followed professional standards. Others are AmeriHealth's own standards, such as the maximum number of patients a physician may see each hour, the size of the patient waiting room, and the maximum length of time a patient may be kept waiting there. AmeriHealth also expects physicians to adhere to its Wellness Guidelines for preventive care and Clinical Practice Guidelines for treating certain medical conditions. AmeriHealth monitors adherence to its Standards and Guidelines through recredentialing site visits and record reviews for PCPs and high-volume specialty physicians, and annual performance reviews and appraisals of PCPs. AmeriHealth attempts to enforce compliance through performance improvement plans and the threat of termination. Indeed, the physicians' Agreements with AmeriHealth give AmeriHealth the unilateral right to terminate the contract for "contract breach" if the physician fails to adhere AmeriHealth's rules, standards or guidelines. To date, AmeriHealth has not exercised such a right of termination, and does not regularly monitor adherence to its quality assurance standards and guidelines by most specialty physicians. However, the common law agency test examines a master's right to control, and not just his exercise of control. See Restatement, Section 220(1). Here, AmeriHealth's standards and guidelines apply to all physicians, as do AmeriHealth's contractual rights of access and inspection. Though a few of AmeriHealth's guidelines and standards are mandated by State law, most are unilaterally determined by AmeriHealth.

On the other hand, the record does not support the Petitioner's assertion that "what goes on" in the physicians' offices is "closely monitored and regulated by AmeriHealth." (P. br. 77.) At most, AmeriHealth representatives visit physician offices for a few hours once every year or two, and even then they only conduct random spot checks of patient records. Many physicians never receive any site visits. AmeriHealth requires that it be notified of services rendered and have access to the physicians' records of such services, but AmeriHealth's standards and guidelines do not attempt to control or supervise the manner in which the physicians or their staffs actually perform the medical procedures and tests for which AmeriHealth pays them. AmeriHealth does not observe the physicians or their staffs providing medical care, and, as a practical matter, has no way of doing so. The Agreements require that the physicians provide services to members "with the same standard of care, skill and diligence customarily used by similar physicians in the community," but AmeriHealth does not define that standard or, as far as the record indicates, attempt to enforce it. For the most part, the medical procedures involved in this case are not performed "under the direction" of AmeriHealth, but "by a specialist without supervision." See Restatement, Section 220(2)(c).

AmeriHealth controls, through its Patient Care Management program, a wide variety of decisions about what services physicians may provide pursuant to their contracts with AmeriHealth (i.e., services for which AmeriHealth will pay them). AmeriHealth determines the sites where certain services must be performed in order to be covered. Through precertification, con-

current review and other case management procedures, AmeriHealth reviews the "medical appropriateness" or "necessity" of procedures recommended by physicians. AmeriHealth also requests and monitors compliance with its Drug Formulary. Notwithstanding this evidence of control, the record does not support the Petitioner's assertion that physicians "must get the approval from AmeriHealth for every significant step in the process of treating a patient." (P. br. 76; see also br. 80) Many, if not most procedures performed by the physicians currently require no precertification. In particular, many routine referrals to specialty physicians are controlled by PCPs, not AmeriHealth. However, AmeriHealth unilaterally sets the scope of its precertification requirements. The set of procedures it reviews is neither mandated nor controlled by State law, and AmeriHealth is free to expand the requirements to encompass other services. Although AmeriHealth ultimately approves most precertification requests, it retains the right to deny them.

As noted above, the record fails to support the Petitioner's assertion that AmeriHealth and other HMOs control the physicians' access to patients. (P. br. 6, 13, 78–79, and 93) AmeriHealth's market share of insured patients in Atlantic and Cape May Counties is less than 10 percent. HMOs have enrolled about 35 percent of the insured population nationwide, though no figures on Atlantic and Cape May Counties were offered into evidence. Given current trends, these market shares may increase, but at the present time there are many insured patients who are not enrolled with AmeriHealth or any other HMO. Not all physicians in Cape May and Atlantic Counties have signed contracts with AmeriHealth. Some who signed, including one of the six physician witnesses at the hearing, have terminated their relationships. It may be true that, in the short-term, an HMO controls access to the HMO's own members because members are unlikely to use out-of-network providers, but there appears to be considerable movement of patients between plans, and physicians appear to have some, albeit limited, influence on where they move. At any rate, the petitioned-for physicians do not exclusively rely on AmeriHealth's marketing to obtain patients, but instead advertise and promote themselves on their own, and add new lines of services to attract patients and increase revenues.

In addition, the physicians maintain their separateness from AmeriHealth. See Restatement, Section 220(2)(h). AmeriHealth has no direct financial interest in the physicians' practices. The physicians are free to contract with other insurance companies, including competing HMOs, and all or nearly all have done so. In fact, AmeriHealth patients account for only a small portion of the medical services the physicians provide. Physicians are also free to provide noncovered services to AmeriHealth members, if the members are willing to pay for them. The physicians advertise and do business in their own names or the names of their practices, and not in AmeriHealth's name. They compete for patients against other physicians within AmeriHealth's network. The physicians are highly skilled professionals engaged in a distinct occupation who receive no training from AmeriHealth. See Restatement, Section 220(2)(b) and (d). As members of their profession they must abide by standards and ethical rules apart from any requirements that AmeriHealth may impose. They do not work at AmeriHealth's facilities, but instead supply "the instrumentalities, tools and the place of work." See Restatement, Section 220(2)(e). Thus, the physicians lack the "close economic relation" and integration with AmeriHealth that would support a finding of employee status. See Restatement, supra at 479.

The physicians also make important business decisions that affect the profitability of their practices. AmeriHealth pays physicians not "by the time" but "by the job." See Restatement, Section 220(2)(g). The physicians receive a flat rate either per member/per month under capitation or per service under fee for service, while they are responsible for all the expenses of their practices. Thus, physicians have the opportunity to use their professional and business judgment to operate efficiently to maximize their profits or compensation. They decide whether they will associate with other physicians, and how their practices will be organized and owned. Beyond AmeriHealth's very basic equipment and facility requirements, the physicians make all decisions about how many locations to operate, what facilities and medical equipment to use and whether to purchase or lease them. Physicians are free to expand their facilities, offer new services, contract their practices or sell them. They decide how many staff members to employ, determine their duties and compensation, and supervise them. Other than having to meet AmeriHealth's minimum office hours requirements, the physicians set their own hours. Physicians use payroll and billing services, accountants, lawyers, and business consultants to assist them in managing their practices. They make investment decisions, and decide how much they will be compensated after other practice expenses are paid.

Finally, the record does not support the Petitioner's assertion that "the physicians do not have a meaningful opportunity to negotiate over the terms, or the fees provided by AmeriHealth for their services." (P. br. 13; see also P. Br. 77, 95–96) Clearly, AmeriHealth attempts to maintain a standard fee structure and discourages individual negotiations. Nonetheless, it has negotiated "special prices" with 10 percent or more of the physicians. For many physicians, AmeriHealth can impose its own price schedules, as evidenced by AmeriHealth's unilateral imposition of fee for service reductions in July 1998. However, in response to those new fees a number of physicians sought and obtained revised offers from AmeriHealth. The Board found in *Dial-A-Mattress Operating Corp*., supra, 893 that the owner-operators in that case had "freedom to negotiate special deals" because the record showed that some had done so, and that this freedom did not "become illusory simply because Dial rejected offers from other owner-operators under different circumstances."

The Petitioner advances another argument in support of its position that warrants consideration. It contends that the physicians' dealings with other HMOs should not be considered a factor weighing against a finding of employee status. Rather, the Petitioner argues, the physicians are "in effect, part-time employees of several different HMOs." (P. br. 11, fn. 20) By this argument, the physicians are employees of AmeriHealth with respect to the work they perform for AmeriHealth patients, and perhaps also employees of other HMOs with respect the work they perform for the other HMOs' patients.

In *Town & Country Electric*, supra, 516 U.S. at 94–95, the Supreme Court applied common-law agency doctrine in holding that an individual may be a statutory employee of two employers at the same time, so long as service to one does not involve abandonment of the service to the other. See Restatement, supra, Section 226. The Board has found individuals to be employees of an employer, even though the employees may perform the same work for others during the same period.

Thus, for example, the Board found that contract photographers for a newspaper were employees and not independent contractors, despite the fact that they were paid a fixed sum per assignment, used their own camera equipment and supplies, covered their own expenses for local assignments, had discretion to determine the manner in which assignments were performed, and were free to sell their work to others. *The News-Journal Co*., 227 NLRB 568, 570–572 (1976). However, unlike the physicians in this case, the photographers were not allowed to sell their work to the employer's competitors. They were also guaranteed a minimum number of assignments per week, and regularly used the employer facilities for darkroom work.

The facts of the instant case are more similar to the relationship between the advertising agency and the freelance advertisement photographers who were found to be independent contractors in *Young & Rubicam International*, 226 NLRB 1271 (1976). Those photographers, like the physicians in this case, were highly skilled professionals with particular specialties. They rented and maintained their own facilities at their own expense, invested in expensive photographic equipment, employed their own employees whom they compensated with wages and benefits, were incorporated as businesses, retained agents, and ran advertisements to promote their businesses, and were paid a flat fee for most assignments. The photographers' work was often closely monitored and supervised by art directors for the advertising agency so as to achieve the agency client's desired result. However, the technical means by which the photographers carried out the art directors' instructions were left to the photographer. The Board found that the character of the freelance photographers' operations was essentially entrepreneurial, in that they received a flat fee from which they had to cover a number of unreimbursed expenses over which the photographer, and not the advertising agency, had control. In concluding that the photographers were independent contractors notwithstanding the control exercised by the artistic directors, the Board quoted from an earlier decision:

> When one engages a contractor to build a house, the contractor does not become any less independent because the purchaser determines the kind of house, where it is to be placed, the kind of materials to be used, the times of construction, or even the times of day when building shall take place.

Id. at 1275, quoting from *Associated Musicians Local 16 (The Manor),* 206 NLRB 581, 589 (1973), enfd. 512 F.2d 991 (D.C. Cir. 1975). See also *DIC Animation City*, 295 NLRB 989 (1989); *Big East Conference*, 282 NLRB 335 (1986), enfd. 836 F.2d 143 (3d Cir. 1987); *Boston After Dark*, 210 NLRB 38, 42–43 (1974); and *WFMF*, 198 NLRB 923 (1972).

In the instant case, the record evidence describes a complex relationship between an HMO and private practice physicians where, previously, no similar relationship existed. Applying the common-law of agency standard set forth in the Restatement, I find that while AmeriHealth controls, or has the right to control, which particular health care services the physicians provide AmeriHealth members that will be covered by AmeriHealth's insurance plans, AmeriHealth lacks substantial control "with respect to the physical conduct in the performance of the services" the physicians provide. The means by which the physicians examine patients, administer screens, diagnose illnesses, and perform procedures, are generally left to the physicians' discretion. Although the physicians' relationship with AmeriHealth is continuing and indefinite in duration, the physicians retain their economic separateness from AmeriHealth. They are engaged in a distinct occupation and practices that exist independently of AmeriHealth, and do business and advertise in their names. They are skilled specialists who supply the instrumentalities and tools of their trade, and who perform the work at their own facilities without AmeriHealth's supervision. They are paid fees "by the job" from which they must cover a wide variety of unreimbursed expenses, including the wages and benefits of their own employees. It is the physicians, and not AmeriHealth, who control these expenses. While the economics of the industry may be changing, the record shows that the physicians in this case retain wide entrepreneurial discretion in how they run their practices and make profits. The physicians' activities are not "controlled by their sense of obligation to devote their time and energies to the interests" of AmeriHealth's enterprise, but to the interests of their patients and practices. See Restatement, supra at § 479. Accordingly, I find that the factors of the common-law agency test weigh heavily in favor of independent contractor status for the petitioned-for physicians, and conclude that the physicians are not employees of AmeriHealth but are independent contractors within the meaning of the Act.

ORDER

IT IS ORDERED that the petition filed here be, and it is, dismissed.